South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) - Work Phone: ( ) - Carrier: _____

Preparer's Name: _____ Preparer's Phone #: ( ) -

Date of injury: _____

The above-named parties agree to pay and accept compensation based on the following facts:

On _____ (month/day/year), the treating physician,_____ (Name of Treating Physician), assigned a _____ percent permanent impairment rating to the _____ (Body Part). The parties agree that the Claimant reached maximum medical improvement on _____ (month/day/year) and has sustained _____ percent permanent disability to the _____ (Body Part) and/or _____ weeks disfigurement as a result of his/her injury. The Employer's Representative agrees to pay and the Claimant accepts _____ weeks of compensation at the rate of $_____, which is based on the Claimant's average weekly wage of $_____. The estimated award is $_____, which is subject to verification by the Commission.

This agreement is binding on approval by the Commission. A claim for additional compensation based on a worsening of the Claimant's condition must be filed no later than one (1) year from the date of the last payment of compensation. Only medical care authorized by the employer's representative, or specific medical care detailed herein, will be paid under the terms of this agreement.

Claimant's Signature

Employer's Representative

☐ Witness ☐ Claimant's Attorney (check one)

Commissioner

Date Agreement Signed

Date Approved

Refer to R.67-804 for instructions regarding the Form 16